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ASSESSING AND FORMULATING ACUTE RISK FOR SUICIDE

Case Example – "Mr. AJ"

- 43 year old male self-referred for outpatient evaluation of depressive symptoms
- Positive neurovegetative profile
- Endorses passive suicidal ideation
- Drinks alcohol daily – increasing use recently
- No past history of suicide attempt
- Grandfather died by suicide

Assessing a Patient's Risk for Suicide Begins with Understanding Research-Based Risk Factors

Front porch forecasters

Case Example

- Mr. AJ's Beck Depression Inventory – II score is 29
- His Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) score is 9

Case Example

- Mr. AJ is having marital problems and has felt overwhelmed with increased job demands in the context of layoffs at his company

Case Example

- Mr. AJ reports feeling that he would be better off dead right now, but states, “I wouldn’t do anything to hurt myself”
- He has had thoughts of suicide in the past during the end of his first marriage
- He has not attempted suicide previously

A Segue

- ***Formulating Risk*** is dependent, first and foremost, on understanding risk (both chronic and acute, based on empirical findings) and in asking sufficient questions to elicit reliable information to inform that understanding.

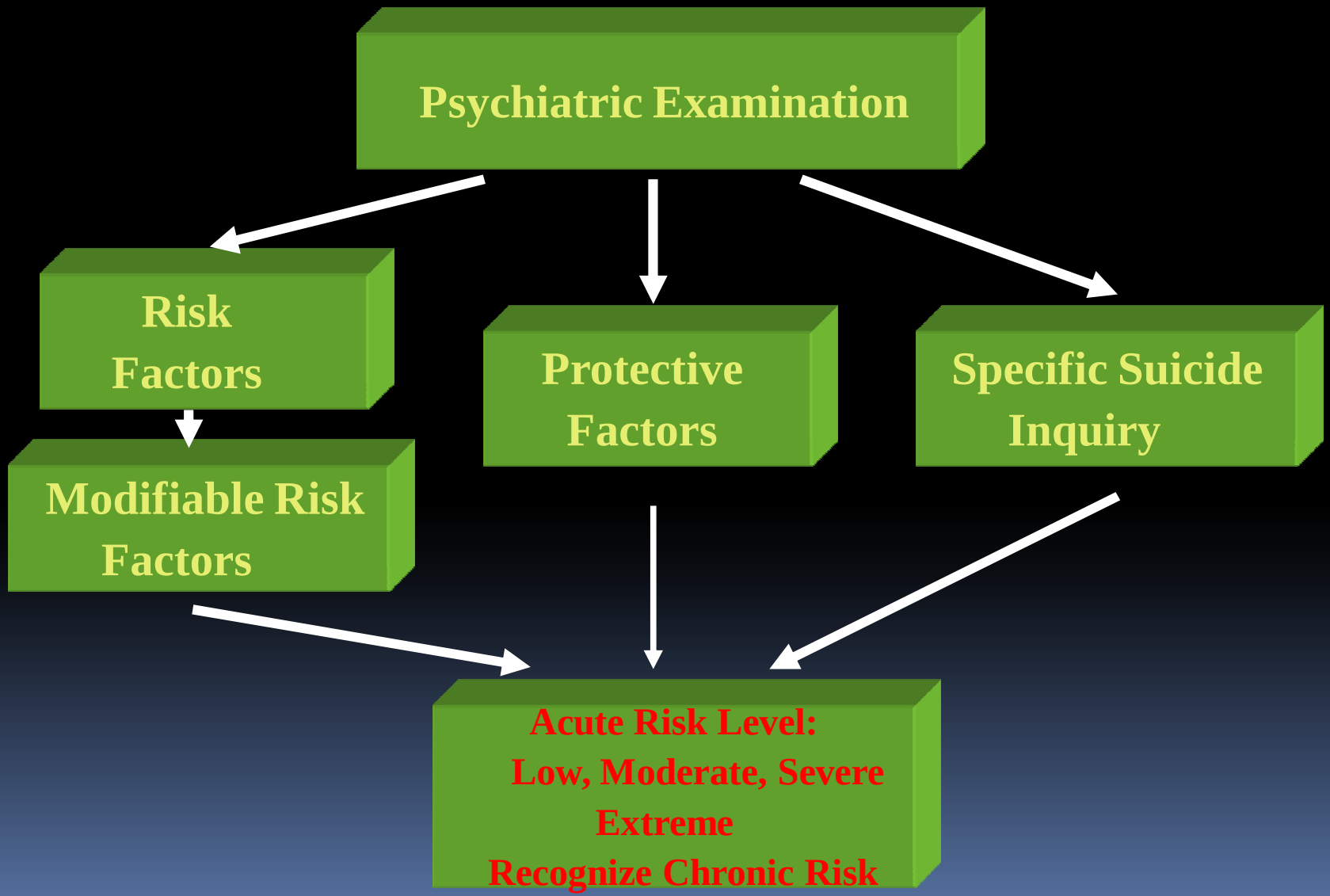
Approaches to Risk Formulation

- Once relevant information has been observed and documented, a judgment of your patient's level of risk must be made.

Skill Set V: Formulating a Judgment of Level of Risk

- Make a clinical judgment of the likelihood that a patient will attempt suicide in the short and long-term
  - Apply understandings of risk based on research
  - Integrate and prioritize information
  - Engage in critical thinking
  - Assess patient's motivation to minimize risk
  - Assess patient's motivation to exaggerate risk

DETERMINATION OF LEVEL of RISK



Formulation of Risk

- Make clinical judgment using ***ALL*** data.
- Articulate rationale for judgment in clinical record.
- Consult with colleagues/supervisors whenever possible.
- Distinguish between signs of ***ACUTE*** risk (associated with increased likelihood of suicidal behavior in short-term) versus CHRONIC risk (long-term vulnerability to be suicidal).

Index of Suspicion: Suicide Risk

- Behavioral observations that risk is increased
  - Indirect references to own death; arrangements made
  - Recent disruption in interpersonal relationship
  - Negative environmental changes; threat of exposure (shame/guilt);
  - Recent psychiatric hospital discharge
  - Recent significant medical care with anxiety-provoking diagnosis or increased sense of burdensomeness
  - Abrupt clinical change
  - Current hopelessness and/or anger
  - Increased perturbation (agitation)
  - Indifference or dissatisfaction with therapy; elopements and early pass return from hospital

Most Observable Acute Risk factors

- ***Acute Onset of Psychiatric Symptoms***
  - "psychological pain"
  - "depressive turmoil"
  - delusions
  - command hallucinations
  - diminished concentration
  - insomnia
  - anxiety/agitation ("panic")

Acute Risk
(demands immediate clinical attention)

- Current ideation or suspected, but denied ideation
  - Current disinhibition/dysregulation
- Current or recent suicide threats
- Evidence of current or completed resolved plans or preparations, e.g. attempts to find weapon
- Recent (last year) nonfatal attempt with intent to die

Acute Risk

- Associated Circumstances
  - Suicide note written; financial records organized
  - Lethal method accessible
  - Precautions taken versus discovery or rescue/intervention
  - Evidence of rehearsal behavior
  - Current alcohol overuse

Acute Risk

- Major depression with:
  - Severe agitation, psychic anxiety, panic; severe obsessive ruminating/compulsive behaviors
  - Global insomnia
  - Severe anhedonia
  - Diminished concentration, indecision
  - Current episode of cycling affective disorder
- Isolation (lives alone; 1st 24 hours' incarceration)
- Exposure to recent media publicity about suicide
- Perceived sense of burdensomeness

Red Flags (an acronym and mnemonic)

- ***IS PATH WARM?***

The following acute risk factors have been found to be most associated with increased risk in the near-term and may be readily recalled via *IS PATH WARM?*

IS PATH WARM?

- I **Ideation**/threatened or communicated
- S **Substance Abuse**/excessive or increased

- P **Purposeless**/no reasons for living
- A **Anxiety**, Agitation/Insomnia
- T **Trapped**/feeling no way out
- H **Hopelessness**

- W **Withdrawal** from friends, family, society
- A **Anger** (uncontrolled)/rage/seeking revenge
- R **Recklessness**/excessively risky acts - unthinking
- M **Mood** changes (dramatic)

An example of a Chronic and Acute Risk Factor

- A history of psychiatric hospitalization is a significant **chronic risk factor.**
- **Acute risk** is highest immediately after discharge from inpatient psychiatric hospitalization.

Relative Risk of Completed Suicide

- **Discharge from Psychiatric Hospital**

	Odds Ratio
Last week	**278***
Last month	133
Last year	34-61

- Particularly for brief hospitalization for affective disorder with symptom improvement; limited external resources
  - Qin & Nordentoft (2005)

Models for Formulating Risk

- There is no agreed upon model for formulating level of risk that has any degree of actuarial validity, but we propose the following model for your consideration:

Model: Acute Risk in the Context of Chronic Risk

- This model asserts that the formulation of level of risk rests first on evidence that there is acute risk in the context of a patient's vulnerability to be suicidal.

- It further assumes, based on research evidence, that:
  - The presence of multiple risk factors increases risk
  - Protective factors do not protect when there is significant acute risk
  - The greater the presence of acute risk, the greater the risk

- Step 1 in the model requires a scaling of both chronic and acute risk factors. For example:
  - Chronic: None – Low – Moderate -- High
  - Acute: None – Low – Moderate -- High

Formulating Risk: Example 1: Depressed Patient

A 44 year old married female with a chronic history of depression and current problems sleeping seeks therapy. She denies SI and ascribes her insomnia to worry regarding recent problems with her teenage son. Her mother and maternal grandfather were depressed.

Level of Risk	Chronic Risk	Acute Risk
Low	Dysthymia Family hx of depression	Insomnia
Moderate		
High		

Formulating Risk: Depressed Patient: ***Low Risk***

Level of Risk	Chronic Risk (vulnerability)	Acute Risk (perturbation)
Low	+ Patient has some vulnerability	+ Patient has low acute risk
Moderate		
High		

Formulating Risk: Example 2: Depressed Patient

A 44 year old divorced male attorney with symptoms of major depression is referred by the managing director of his law firm because of recent inappropriate behaviors while under the influence of alcohol. The patient admits that his drinking has increased, that he is enraged at his ex-wife's attempts to limit his visitation rights with his children, that he has harbored fantasies of killing her or himself "on her doorstep." He sleeps fitfully, frequently goes to work with a hangover and, consequently, has been "screwing up" in his client work. He sees no way to change what is going on. He appears to have narcissistic personality traits and states that he was sexually abused by his parish priest when he was 8-10 years old. He has withdrawn from his friends who have complained of his embarrassing behaviors.

Level of Risk	Chronic Risk	Acute Risk
Low		
Moderate	MDD Divorced Hx of abuse Co-morbid Narcissistic PD	•Increased ETOH, with consequent insomnia •HI/SI (revenge fantasies) •Trapped/Hopeless •Withdrawal
High		

Formulating Risk: Depressed Patient: High Risk

Risk Level	Chronic Risk Factors	Acute Risk Factors
Low		
Moderate	+ Patient has a moderate degree of vulnerability	
High		++ Patient has considerable acute risk and crumbling protection

Formulating Risk: Example 3: Mr. AJ

Level of Risk	Chronic Risk	Acute Risk
Low		
Moderate	Middle-aged male Family hx suicide Prior hx SI MDD	•SI (passive)/denied intent •Increased ETOH •Increased stress/distress •Increased anxiety •Insomnia
High		

Formulating Risk:
Mr. AJ: Moderate to high Risk

Risk Level	Chronic Risk Factors	Acute Risk Factors
Low		
Moderate	+ Patient has a moderate degree of vulnerability	
High		+ to ++ Patient has moderate to high acute risk

Suicide Risk Assessment Guidelines

Risk assessment is intimately tied to treatment planning: Triage and treatment decisions follow a careful assessment and formulation of level of risk.

- Closeness of observation/monitoring
- Decision to hospitalize
- Need for means restriction
- Targeted risk-factors to decrease
- Targeted protective factors to strengthen

A Final Note: re Documentation

- Lawsuits alleging malpractice in cases of suicide may be won or lost on the basis of what was contemporaneously documented about the patient.
- A documented clinical judgment of risk is the single most important legal defense.
- That judgment should be based on observations of risk, clinical reasoning and rationale, and tied to a treatment plan.